

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004419	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/17/2014
NAME OF PROVIDER OR SUPPLIER WHITLOCK PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 S ELM ST CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00156848.</p> <p>Complaint IN00156848 - Unsubstantiated due to lack of evidence.</p> <p>Survey date: October 17, 2014</p> <p>Facility number: 004419 Provider Number: 004419 Aim Number: N/A</p> <p>Survey team: Lora Brettnacher, RN, TC Tracina Moody, RN Megan Burgess, RN</p> <p>Census bed type: Residential: 46 Total: 46</p> <p>Census by payor type: Other: 46 Total: 46</p> <p>Sample: N/A</p> <p>Whitlock Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00156848.</p> <p>Quality Review 10/20/14 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE